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**UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF CALIFORNIA
FRESNO DIVISION**

In re:)	Case No. 16-10015-A-9
)	
)	Chapter 9
Southern Inyo Healthcare District)	
)	13th REPORT OF THE
)	PATIENT CARE OMBUDSMAN
)	
Debtor.)	(No Hearing Required)

Pursuant to the order directing the appointment of a Patient Care Ombudsman entered by this court on February 17, 2016, Tracy Hope Davis, the United States Trustee, duly appointed Joseph Rodrigues, the California State Long-Term Care Ombudsman, as the Patient Care Ombudsman in this case.

In compliance with the notice of appointment, the Patient Care Ombudsman is submitting his 13th report, covering the period January 3, to March 2, 2018.

Respectfully submitted,

/s/Joseph Rodrigues
Joseph Rodrigues
State Long-Term Care Ombudsman

1 **13th REPORT OF THE PATIENT CARE OMBUDSMAN**

2 Eastern Sierra Area Agency on Aging is the designated Long-Term
3 Care (LTC) Ombudsman Program for Inyo and Mono Counties and is the
4 local representative of the Office of the State LTC Ombudsman. As
5 mandated by the federal Older Americans Act (42 U.S.C. 3058g), LTC
6 Ombudsman representatives identify, investigate and resolve
7 complaints that are made by, or on behalf of residents of LTC
8 facilities that relate to action, inaction or decisions that may
9 adversely affect the health, safety, welfare or rights of residents.
10 Paulette Erwin is the local Ombudsman representative assigned to
11 this facility.
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14 Southern Inyo Hospital District is located at 501 E. Locust
15 Street, Lone Pine, California. The California Department of Public
16 Health (CDPH), Licensing and Certification Division, licenses this
17 facility as a Skilled Nursing Facility (SNF). SNFs provide housing,
18 meals, medical care, personal care, social services, and social
19 activities to people who have physical or behavioral conditions that
20 prevent them from living alone.
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24 The following information describes the number of visits made
25 to the facility (complaint and non-complaint related), observations
26 about privacy, food, the general status of the residents, any
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1 complaints made by or on behalf of residents to the LTC Ombudsman
2 Program, and any changes in the census of the facility.
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5 The licensed capacity of the facility is 33, with a current
6 occupancy of 27. Assistant Director of Nursing, Tambria Kalenowski
7 advised in order to meet the required nursing hours per resident per
8 day they would be unable to accept new residents until there is a
9 change in occupancy and/or staffing. There is no noted significant
10 change in resident mix, such as the admission of different client
11 groups, younger residents, etc.
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14 Hospital Administrator, Brian Cotter, reports that an
15 individual has accepted the Director of Nursing position and will be
16 starting on March 5, 2018. Until this time, Michael Floyd will
17 continue to work as the acting Interim Director of Nursing. The
18 facility has hired Jayneann Hinek as Director of Staff Development.
19 Because of the rural nature of this facility, retaining qualified
20 licensed personnel continues to be a challenge.
21

22
23 The local Ombudsman Program has not received any concerns
24 involving vendors, utilities, or external support factors that may
25 impact resident care.
26

27 The local Ombudsman Program has conducted four visits during
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1 this reporting period. During these visits, the Ombudsman
2 representative noted the facility appeared to be clean with no
3 overwhelming odors. Residents appeared clean and were appropriately
4 dressed for the time of year and day. Menus and activity calendars
5 were posted and residents reported being satisfied with their
6 choices.
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9 The local Ombudsman Program received a total of four cases and
10 six complaints. The complaints during this reporting period include
11 the following:
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14 A complaint related to the resident not being informed of a
15 room transfer. The Ombudsman representative and resident met with
16 facility staff to discuss the resident's complaint. The Ombudsman
17 representative provided information on intrafacility transfers and
18 providing reasonable notice. Facility staff agreed to give the
19 resident an option of two different rooms. The resident was
20 satisfied with the outcome of the complaint.
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22
23 A complaint related to the facility failing to schedule a
24 resident for an ongoing urologist appointment. The Ombudsman
25 representative met with the Assistant Director of Nursing who
26 advised an appointment had been scheduled with an urologist and they
27 were working on arranging transportation. Two weeks later, the
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1 resident was taken to the appointment and a preoperative appointment
2 was scheduled.

3
4 A complaint related to dietary services. The Ombudsman
5 representative and resident met with dietary staff and discussed the
6 resident's special dietary needs and preferences. An individualized
7 meal plan was developed to ensure the resident was receiving a well-
8 balanced diet.
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10
11 A complaint related to the heating equipment not working
12 properly in a resident's room. The Ombudsman representative
13 reported to the Assistant Director of Nursing who contacted
14 maintenance. Three days later, the resident agreed to move to
15 another room that was warmer and the heater did not make a buzzing
16 sound.
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19 A complaint related to resident to resident physical abuse.
20 The Ombudsman representative met with residents who indicated the
21 situation had been resolved and declined Ombudsman services.
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24 A complaint related to suspected verbal abuse. A resident
25 reported to the Ombudsman representative that a Certified Nursing
26 Assistant was being verbally abusive. The Ombudsman representative
27 met with Assistant Director of Nursing regarding the complaint and
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1 discussed strategies to implement to ensure the resident felt safe
2 during the investigation. The Ombudsman representative cross-
3 reported the alleged verbal abuse complaint to California Department
4 of Public Health. The California Department of Public Health
5 notified the Ombudsman representative that the compliant allegations
6 were unsubstantiated, but they did identify other unrelated
7 violations during the onsite visit.
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10 The Patient Care Ombudsman has no recommendations for the court
11 at this time.
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13
14 March 2, 2018

/s/Joseph Rodrigues

Joseph Rodrigues

State Long-Term Care Ombudsman